

CRAVEN COUNTY SCHOOLS

REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

To be completed by a Licensed Health Care Provider

Name of Student: _____ School: _____

Medication: _____ Dosage: _____ Route: _____

Time(s) medication is to be given at school: a.m. _____ p.m. _____

To be given from (date) _____ to _____

Significant Information: Include side effects, toxic reactions, and omission reactions:

Contraindication for Administration: _____

FOR SELF ADMINISTRATION: A treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 116C-375.2

Student has demonstrated understanding of and ability to self-administer asthma, diabetes, allergy medication as prescribed and may carry:

- MDI/MDI with spacer (*medicated dose inhaler, parent must provide an extra inhaler to be kept in school in case of emergency-stated in G.S. 116C-375.2)
- Epi-pen
- Insulin

Licensed Health Care Provider **Date**

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PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a Licensed Health Care Provider. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication. **All medication for use at school will be furnished by parent/guardian in a container properly labeled by a pharmacist with identifying information (name, medication, dosage, time it is to be taken).** If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

- a. Contact Dr. _____ at Phone _____
- b. Take child immediately to the emergency room at _____

Signature of Parent/Guardian **Phone Number** **Date**

Reviewed by: _____
School Nurse's Signature **Date**